

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

7970 = 62-033037  
STATE FILE NUMBERDO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED AUG 22 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>S T. LOUIS, MO.</u>		Length of stay in 1b <u>40 yrs</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>		d. STREET ADDRESS (If outside, give location) <u>1116 S. Jefferson Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>BENNIE</u> Middle <u>WILSON</u> Last		4. DATE OF DEATH Month <u>AUG</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (City and state or country) <u>Adams County Miss. U.S.A.</u>	
13a. FATHER'S NAME <u>Nathaniel Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Rachel Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>Malchia Wilson 2920 Delmar Blvd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension of undetermined etiology &amp; -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Tubercular disease</u> DUE TO (c) <u>467.0</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>8-10-62</u> to <u>8-12-62</u> and last saw him alive on <u>8-12-62</u> Death occurred at <u>2:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thomas J. Ridzon M.D.</u> (Degree or title)		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	
22c. DATE SIGNED <u>8/12/62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>8-17-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	
23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>		24. FUNERAL DIRECTOR <u>JAS. H. RANDLE &amp; SON</u>	
24. ADDRESS <u>3133 Bell Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 15 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Hoan Smith, M.D.</u>			

Thomas J. Ridzon, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Esder H. Harner*

Licensed Embalmer No.

*4458*

P. O. Address

*4181 Washington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.